REDESIGNING ACUTE CARE FOR OLDER PEOPLE

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Figure 6 Needs-weighted emergency bed days per person over 65 per annum for the four PCT groups identified

Source: The King’s Fund analysis of HES data 2006/7 and 2009/10, and ONS Mid-year population estimates 2007
Figure 32: Emergency admissions from accident and emergency departments, monthly data

Data source: A&E attendances and emergency admissions www.england.nhs.uk
Figure 34: Delayed transfers of care: number of patients delayed on last day of month

Admission
Avoidance
“… a short term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. The care is person-centred, focused on rehabilitation and delivered by a combination of professional groups”
OTHER DEFINITIONS

- Reablement
- Enablement
- Rehabilitation
- Respite
- Enhanced assessment
- Interim bed
- Step up/ step down
- Etc etc etc
Figure 6.4.3: Referrals per 100,000 weighted population (mean)
Figure 6.5.2: Average waiting time referral to assessment

- Home based IC
- Bed based IC
- Re-ablement

Average wait (days)

- 2013
- 2014
Comprehensive geriatric assessment (CGA) is a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person’s medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow up.
WAYS OF DELIVERING ‘FRONT DOOR’ GERIATRIC MEDICINE INPUT

- Separate ‘take’ model
- OPAL
- Frailty units
- In the ED
- In the MAU
OPAL (THE ORIGINAL)

- Early CGA to older medical inpatients leading to targeted geriatric intervention
- Aim to improve processes, thus quality of care and length of stay
- Screened admissions >70 years looking for predictors of prolonged length of stay
- Rapid transfer to specialist ward
- Case management on general ward
- Facilitated discharge with onward referral

Improvement in management of ‘geriatric giants’
Mean transfer time to specialist ward fell by 7 days
Mean LOS fell by 3 days
No increase in readmissions or referrals to intermediate care

WAYS OF DELIVERING ‘FRONT DOOR’ GERIATRIC MEDICINE INPUT

- Separate ‘take’ model
- OPAL
- Frailty units
- In the ED
- In the MAU
Patient flow analysis and quality improvement methodology

Radical re-design of the system of care

Reductions in bed occupancy and mortality without increase in readmissions

No additional resource cost

One ward closed and resources transferred elsewhere

Daily bed occupancy run chart for GM with annotations identifying system changes and unusual patterns.
WAYS OF DELIVERING ‘FRONT DOOR’ GERIATRIC MEDICINE INPUT

- Separate ‘take’ model
- OPAL
- Frailty units
- In the ED
- In the MAU
THE NEAR FUTURE

- Vanguards
- Devo-Manc
- Birmingham
- Lessons from the devolved nations
- ‘Extensivist’/ managed care pathways
THANK YOU
ANY QUESTIONS?
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